AGENDA

- **Introduction**

- **Part I: Review court rulings in two cases involving head trauma/multiple caretakers**
  - Overview of Head Trauma
  - Review Medical Evidence Presented in Court the M&D Cases
  - Implications for Practice

- **Part II: Practice approaches and, strategies**
  - Dialoguing with Doctors
  - Morning Break
  - Reflecting on Biases/Reducing Common Errors
  - Timely & Thorough Initial Interviews

    - **LUNCH BREAK (45 minutes: noon-12:45)**

  - Integration and Application Activity using M case
  - Timelines
  - Scene Investigation, with Re-enactment
  - Supervision and Documentation

Why We are Here Today

- **Impetus for training on Medical Issues in Head Trauma Cases**
  - The OIG recommended a training be developed to address recent court rulings involving two separate death cases Illinois.
  - Both cases involved multiple caregivers.
  - Both cases involved abusive head trauma that was ruled to be the caused of death of the involved children.
  - Although both cases were indicated for a specific caregiver, due to court testimony of national medical experts and scientists, both cases were overturned on appeal and the identified perpetrator was changed to “unknown”.

Why We are Here Today (cont.)

- **Supporting Effective Investigative Practice**
  - The conclusions of initial medical experts regarding the identity of the perpetrator were at issue in both court cases, not DCP investigative practice.
  - However, in reviewing one of the cases, many of the common errors highlighted in the Error Reduction training were present.
  - We are therefore taking this opportunity to address these common errors and promote effective practice strategies.

Overall Purposes of the Training

Using the D & M Cases Together We Will:

- Increase knowledge of how initial medical expert conclusions about the timing of the injury and identity of the perpetrator were overturned in court as a result of scientific testimony that increased uncertainty about these conclusions.

- Promote the importance of good investigative practice in Head Trauma cases, especially with regard to: **Dialoging with doctors, Timelines, Scene Investigations, Initial interviews and use of Supervision and Documentation.**

Supporting Previous & Future Training and Policy Revisions

- OIG Error Reduction (ER)Training for Investigations (some in Foundation)
- Foundation Training : basic information about abusive head trauma
- Upcoming Model of Supervision
- Supports Revised Procedures 300
- Increased emphasis on multi-disciplinary teams

Handouts and Tools

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- Layers of Skull/Brain
- Dialogue with Doctors: Questions to Ask (on DNET)
- M Case Summary
- Information on Medical Resources on Child Abuse for each Region and the DCFS Liaison
- Scene Investigation Kits for Investigators (see sample)
- Strategies for Counteracting Biases
- Reference Guides for Timelines
- Referral Form for Medical Evaluation (CANTS 65A)

- Quick Investigative Practice Reference Guides:
  - Conducting Initial Interviews
  - Use of Timelines

Overview of Head Trauma

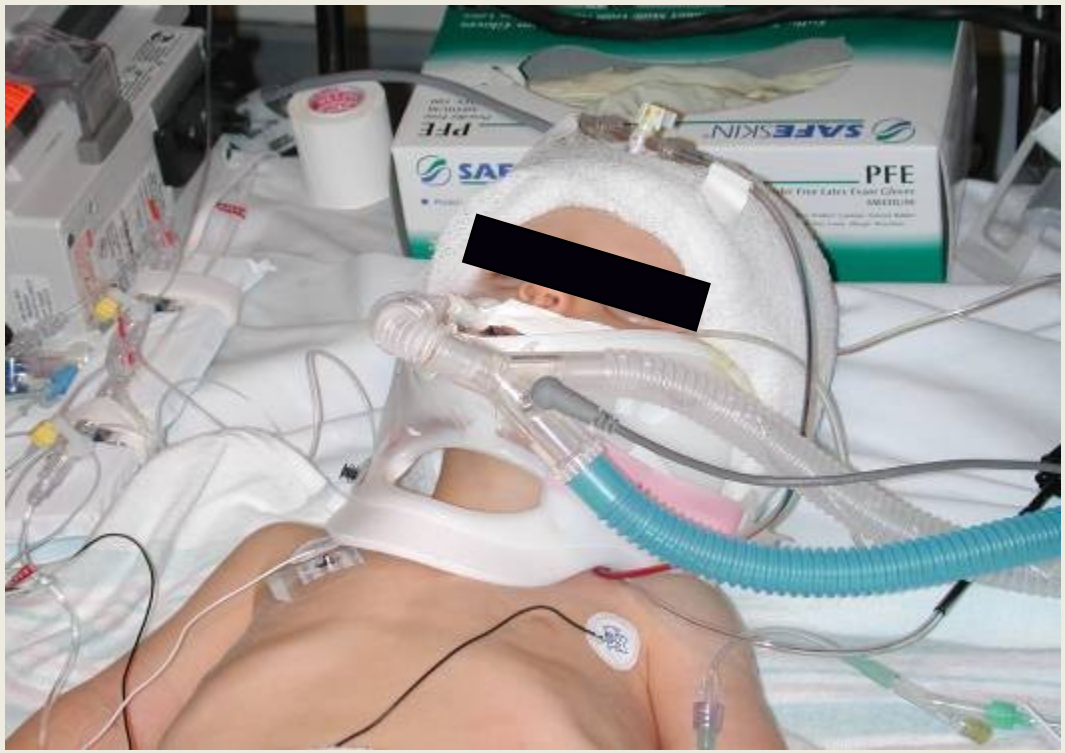
REVIEW OF SLIDES FROM FOUNDATION TRAINING

FY2012 Illinois DCFS Statistics: Brain Damage/Skull Fracture

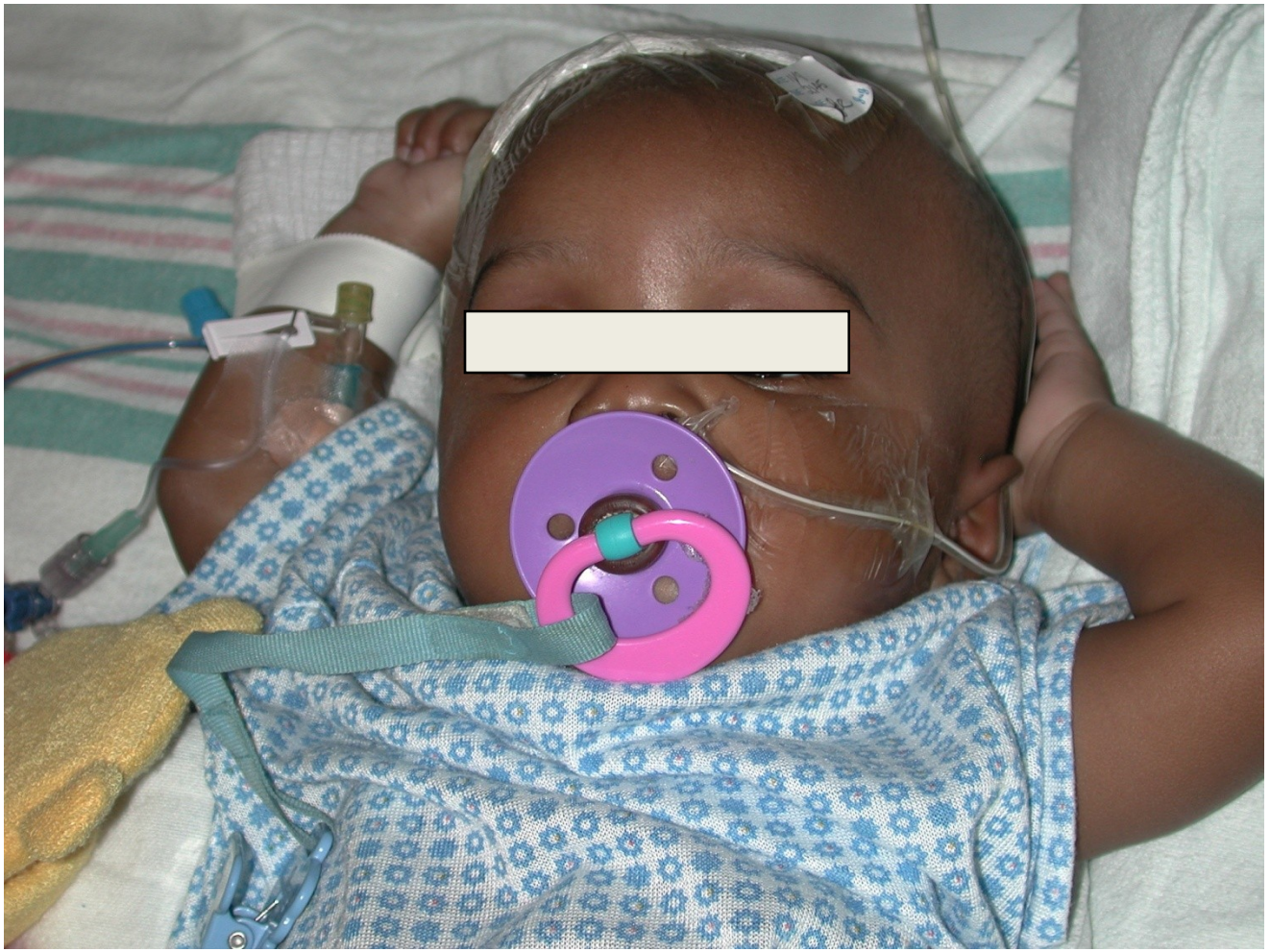
Allegation	Alleged Harms	Indicated	% Indicated
Abuse (#2)	230	104	45.2%
Neglect (#52)	172	49	28.5%

Here is what he looks like: Head Trauma

- **Serious head injury due to abuse or neglect**



But Some Head Traumas Are Not due to Abuse or Neglect



Abusive Head Trauma (AHT)

- Wide range of presenting symptoms
- Infants and young children most vulnerable
  - 50% of infant homicides due to AHT
- Leading cause of death in child abuse cases

Abusive Head Trauma

High morbidity and mortality

- Morbidity conditions
  - Cerebral palsy, seizures, blindness, ventilator dependency, learning disabilities, developmental delay
- Mortality rate of 13-30%

Brain and Brain Injury 101

- The brain is protected by the skull

- How are infants different?
  - Large head in proportion to body
  - Weak neck muscles
  - Bones not fused – “soft spot”
  - Brain high in water content
  - Unable to defend

MULTIPLE CAREGIVERS AND HEAD TRAUMA INVESTIGATIONS

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CASE EXAMPLES AND PRACTICE STRATEGIES

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Mechanisms of Head Trauma (With Types of Injuries)

- **Contact / Impact forces**
  - Cephalohematoma / subgaleal hematoma
  - Skull fracture, epidural hemorrhage, focal subdural/subarachnoid hemorrhage
- **Non-Contact/ Non-impact forces**
  - Rotational injury with acceleration/deceleration
  - Subdural or subarachnoid hemorrhage, axonal (nerve cell) injury
- **Injury from hypoxia (no oxygen) or ischemia (no blood flow)**
  - Cerebral edema (brain swelling) or infarcts (cell death)
  - Cardio-respiratory failure
  - Can be a result of contact and/or non contact forces

Introduction of D Case

D: Medical Conclusions at Issue

Initial Expert Conclusion at Issue	Judge's Evaluation of the Evidence
Fatal Injuries (subdural hematomas, retinal hemorrhages) could only have been caused by last caretaker to have observed child behaving "normally." Child would have "immediately" lost consciousness from these injuries.	• ***Previous injuries (not identified initially) were important:*** There was agreement among most experts on both sides that there were *chronic* subdural "collections" that were at least 2 to 4 weeks old (*it is possible distinguish these injuries from more recent injuries)* at the time the child collapsed. The convicted caretaker was never alone with the child when the earlier trauma was inflicted. • ***Previous injuries could have started bleeding due to even minor trauma:*** Aside from all other testimony, evidence that minor trauma could have caused bleeding from chronic subdural hemorrhages raises reasonable doubt about D's guilt. • Testimony from multiple experts showed "that an infant victim of head trauma can have a **lucid interval** after being subjected to head trauma." (p. 93), meaning that the last person to see child "normal" is not necessarily the one who inflicted the injuries. • **Even national expert (Dr. Jenny) testifying for DCFS/prosecution said**: *"Medicine has come to understand that a child victim of abusive head trauma can have a lucid interval." …"One can no longer say scientifically that the last person with the infant was responsible for abuse."*

M Case: Brief Overview

- JM: 17 month old child with congenital skeletal anomalies, including no left hand or wrist, with a tiny finger like protuberance
- At least 3 people cared for the child the morning that he collapsed—
  - Mother brought child to Godmother before she went to work,
  - Godmother (left for about 45 minutes to get food, came back), and
  - Husband of the Godmother, cared for JM while Godmother was out
- JM brought to hospital by Godmother and her husband with massive subdural hematoma and skull fracture, died the next day
- Husband of Godmother, who was watching the child, was ultimately indicated for death, head injuries, and bone fractures by abuse. (their children were removed)
- Sequence A for Godmother and her husband (no priors for mother either)
- At this administrative expungement hearing, the Administrative Law Judge (ALJ) expunged the record and amended A sequence to be changed to *Unknown Perpetrator*

M Case: Medical Conclusions at Issue

Initial Expert Conclusions at Issue	Judge's Evaluation of the Evidence at trial
Injuries (subdural hematoma, skull fracture, optic nerve and retinal hemorrhages) were **due to abuse**	• **No disagreement among medical experts from both parties:** agreement that injuries were caused by abuse
The **timing of the injuries** would have been "within minutes to an hour" of JM being a "very sick looking child." Child would be in pain and lethargic, if not passed out. JM would not have been able to walk, eat food, or color (per testimony about his recent behaviors) after the abuse. (Testimony of Child Abuse Expert) This **narrow time frame** meant that A (husband of Godmother) was caring for JM at the time of the injury and was the perpetrator of the abuse.	• Testimony of Neurologist (*special certification in child neurology*) given more weight than child abuse expert: could be 0 to 2-3 days since injury, child could sit or eat after injury, or could expire without symptoms. • Two other doctors also would not definitively support narrow window of time when the injury occurred. Medical Examiner, for example, said earlier that the injury happening "recently" meant 1-3 days ago. • ALJ concluded, "The *preponderance of the evidence* established that: it was not possible to set a fixed window of time when the fatal injury occurred and the Department did not meet the burden of proof as to identification of the Appellant as the perpetrator of the abuse."

Court Ruling that Impacts Investigative Practice

- We can no longer scientifically conclude that the last person to care for (or be with) the child before symptoms appeared is the perpetrator

Possibility of a Lucid Interval

- Undermines assumption that last one to see child “normal” inflicted injuries.

- Broadens the time frame for investigating the injury—thereby also expanding the number of caretakers (or others) that should be considered

Important Considerations: *Lucid Intervals*

- Lucid Interval and ability of the legal/medical community to pinpoint the time of injury: an evolving discipline
- Some doctors believe there is a distinction between abusive head injuries caused by blunt force trauma (lucid interval **possible**) and abusive head injuries caused by shaking (lucid interval **not possible**).
- The term “lucid” is confusing with respect to pre-verbal children and infants. How does a “lucid” infant present? And may an injured, symptomatic infant be mistaken for a sleeping infant?

Implications for DCP of Court Rulings

- Keep in mind the complexity of head trauma cases
  - Difficult to determine narrow time frames for when head injuries occurred relative to manifestation of severe symptoms
  - Uncertainty about time frames for when head injuries occur can make it harder to identify a specific perpetrator
  - Any prior head injuries further complicate the investigation

- Regarding timing of injury *recent* subdural hematomas can (sometimes) be distinguished from *chronic* (at least 2 to 4 weeks old) subdural hematomas

Importance of Your Role in Investigating Head Trauma Allegations

- DCP staff are critical in gathering and analyzing information:
  - Can't depend solely on medical experts
  - Examine wider time frames & full range of possible perpetrators
  - Need timely and systematically collected evidence from your interviews along with medical evidence
  - Dialogue with doctors: exchanging information is essential
- We cannot always positively identify the perpetrator.
- Strive for the higher standard of evidence - look beyond the "indicate" decision

Evidence Standard for Child Protection Investigations

- *For indicate decision*, whether "the available facts when viewed in light of surrounding circumstances would cause a reasonable person to believe that a child was abused or neglected." DCFS Rule 300.20

- *On appeal*, the question will be whether the abuse or neglect can be proven by a "preponderance of the evidence," meaning that it is *more likely* than not that the abuse or neglect occurred.

Investigative Practice Strategies

HAVING A PROFESSIONAL DIALOGUE WITH DOCTORS

Review Summary of the M Case

Challenges in Investigating Head Trauma Cases

- **Your thoughts**
  - About the cases—how are they different?
  - What is challenging about these cases?
    - *Family members' possible reactions*
      - *upset and fearful about the injury*
      - *upset and fearful about being investigated and legal implications*
    - *Our possible reactions*
      - *Hard for us to see a child injured so severely*
      - *Wish to believe that someone would inflict the injury (rule of optimism)*
      - *Anger at people who harm children*
      - *Concern about increased workload/responsibilities*
- **How do contextual factors** (e.g., workload and work expectations, when someone else meets the mandate, other?) pose challenges?
- **Other challenges**

The Interview Should be a Dialogue:
Ask Questions and Share Information

- Ask about history of injuries and explanations, any concerns
- Share all relevant information with doctors that you have gathered
- Resolve any discrepant medical conclusions (M.E .vs. consulting M.D.)
- When drawing conclusions
  - Ask what is the *more likely* cause of the injury: abuse or something else (accident, neglect)
  - Clarify with doctors the evidence they are using to draw their conclusions and include this in documentation

Exchange of Information with Doctor

- In order to get a good medical opinion, you must:
  - Share facts with the doctor
  - Ask the doctor pointed questions
  - May need to have more than one conversation with doctor
- Need to adapt based on case
  - May not need to ask every question in every case
  - In serious/complex cases, often need to have more than one conversation with the doctor (give and take is essential)
- D-NET hyperlink to questions to ask doctors - http://dnet2/Content/Frame.aspx?frame=http:// dnet/Inspector_General/OIG_Error_Reduction.asp

A Critical Question for Doctors…

- Given all the facts we've discussed, do you think it is **more likely** that the child suffered these injuries as a result of abuse or accident?
  - Do not ask the doctor whether he or she is absolutely certain
  - The key is *what is more likely!*

A Brief Reminder: Referral Form for Medical Evaluation of …(CANTS 65A)

- 65A not used when child already being treated (e.g., M & D cases)
- Use 65A when abuse is suspected and parents agree to take child
  - Alerts physician of the purpose for the visit
  - Acts as prompt
  - Tells physician the history given for the injuries and risk factors
- Call physician before sharing the form and provide:
  - Reason for the appointment
  - Explanation given for injury
- We (not caregiver) are responsible for getting 65A to doctor
- Completed form not a substitute for conversation with doctor
- If possible, go with child/family to the doctor

Reflecting on Biases to Reduce Common Errors

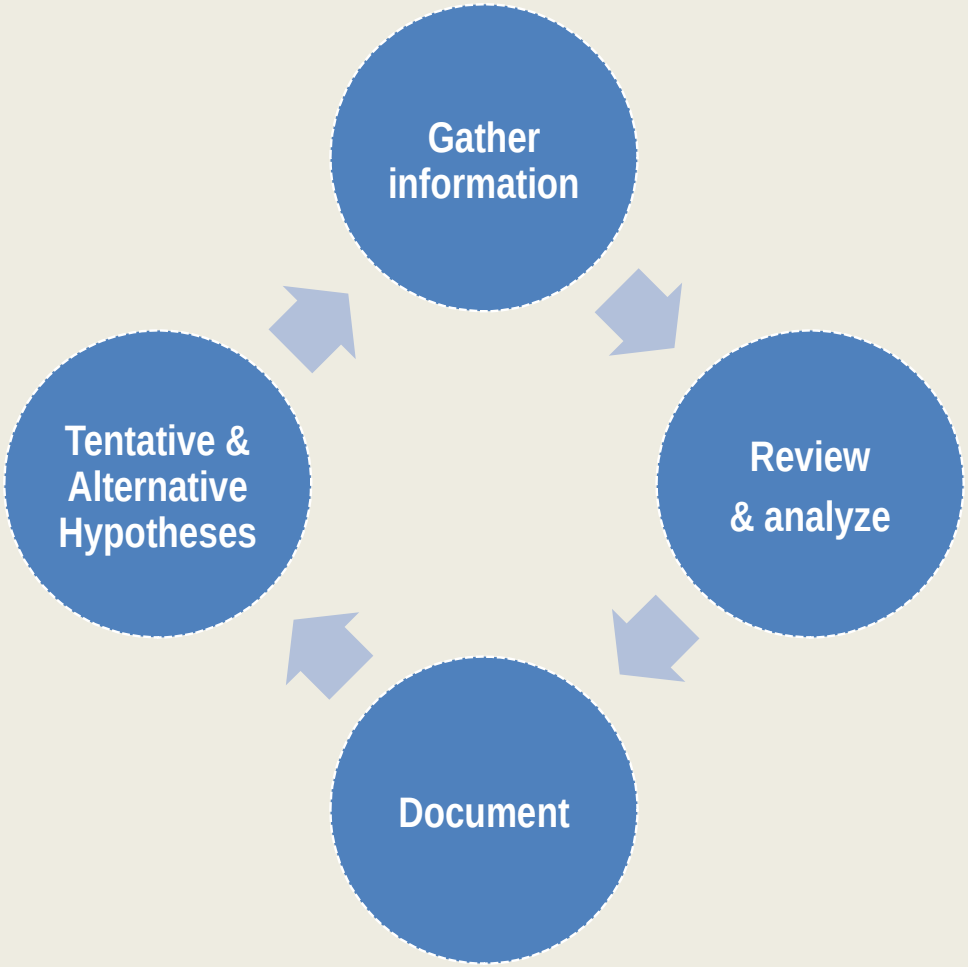
1. **ANCHORING**
2. **RULE OF OPTIMISM**
3. **COUNTERACTING BIASES**

Common Biases that can lead to Errors in Gathering and Using Information

Anchoring (positive or negative)

- Definition: The tendency to believe initial judgments
- "Useful" cognitive strategy for responding to complex information
  - Helps us avoid threats
  - We all do it
  - Judgments based on anchoring might be accurate
- Negative consequences can include:
  - Failure to readjust to conflicting information (e.g., about mother)
  - Selecting and accepting evidence that reinforces the first impression (i.e., confirmation bias)
  - Rejecting evidence that contradicts first impressions
- **Your examples: personal and professional**

Investigative Process: Often Necessary to Refine/Repeat/Corroborate based on New Evidence



Timely & Thorough Initial Interviews

PRACTICE STRATEGIES & APPROACHES

Timely & Thorough Initial Interviews

- **Why focus on this?**
- **Maximize gathering of information in (separate) initial interviews**
  - Efficiency: avoid having to go back multiple times
  - Improve quality of evidence (before people re-think their story)
  - Provide baseline information (e.g., on timeline/explanation): does this remain consistent over time?
- **What are the challenges of conducting initial interviews in Head Trauma cases compared to other cases?**
  - Suggestions for addressing challenges?

Head Trauma with Multiple Caregivers Cases

- Your thoughts
  - About these cases—how are they different?
  - What is challenging about these cases?
  - How do contextual factors (e.g., workload and work expectations, when someone else meets the mandate, other?) pose challenges?
  - Other challenges

- Use the M case to point out practice challenges with the initial interviews

Statement from Law Enforcement Documented in the M case

These are difficult cases. We have a mother who has lost her only child. She calls me every day and asks me what happened to him?

The other caregivers seem to genuinely love the child too. But we have a child who died from abuse. **We all know that anyone is capable of hitting a child.**

Practice Strategies: Timely & Thorough Initial Interviews

- **Timing and Timeliness issues related to initial interviews**
  - Delaying in-depth interviews is problematic (per M case):
    - people can develop a more coherent (inaccurate) explanation
    - people can discuss and agree on their explanations
  - Decide who to interview first (sequence of interviews)
  - Make use of opportunities to interview multiple people early on (e.g., when meeting mandate)

- **Contact doctors and hospitals that have**

Strategies for Preparing for Initial Interviews

- Be prepared, based on initial report and review of prior history:
  - Develop a plan for each interview (with supervisor)
  - Develop a tentative timeline
- Relate critical thinking & systematic data collection strategies to the case
  - Be aware of possible anchoring effects and your own first impressions
  - Consider multiple hypothetical explanations of the incident or injury and gather evidence for and against all hypotheses
  - Gather multiple perspectives (don't rely on self-report--corroborate) and timelines

The Initial Interview Process

- Engagement - Beginning
  - Develop a plan for each interview – who, when, where (with supervisor)
  - Develop a tentative timeline
- Content - Middle
  - Be aware of possible anchoring effects and your own first impressions
  - Consider multiple hypothetical explanations of the incident or injury and gather evidence for and against all hypotheses
  - Gather multiple perspectives (don't rely on self-report--corroborate) and timelines
- Wrap-up - End
  - Develop a plan for each interview (with supervisor)
  - Develop a tentative timeline

Conducting Initial Interviews: Suggestions for Starting the Interview

- Your demeanor: professional, neutral, interested, focused, non-accusatory

- Introduce yourself and why you are there
  - Try to avoid overreacting emotionally--negatively or positively--to their initial responses to investigation/interview
  - Be understanding (but not apologetic) that this is a difficult conversation

Conducting Initial Interviews: Suggestions for Starting the Interview

- Overview of what will happen sequentially during your meeting
  - Where possible, briefly explain the purpose
  - Welcome questions
- Try to make a smooth transition from sharing information to asking questions
  - Explain---you have to ask them some questions about the allegations and want to understand their perspective, but first need to gather some background
- Monitor your own reactions and try to remain respectful, clear, and calm.

Anchoring Bias: Reflect on Your Initial Impressions of Caregiver

- Mother is cooperative/uncooperative/minimally engaged = what?
- Father is angry and shouting/overly cooperative/manipulative = what?
- Provide examples of when initial impressions were:
  - Contradicted later or turned out to be less important
  - Confirmed through other evidence
  - Initial impression way off course

Initial Interviews with Caregivers: General Information vs Incident Specific

- Explain that you need general information about the child and their family
  - Start with what are usually less threatening questions
- General health and development of child
  - Child's doctor? Does the child have any special medical needs?
- Get details (who, what, where, when) on common **routines** (e.g., going to work, taking child to day care, picking child up)
- **Remember:** Initial interviews may provide insight regarding possible underlying conditions with

Initial Interviews: Identifying Possible Multiple Caregivers

- Who is in the home?
  - Address any unrelated adults living in or frequenting the home
  - Using CANTS and LEADs to better assess safety or risk concerns
  - Apply paramour policy when applicable
- Recent **changes** (housing, relationships, caregiving, school, doctor)
- Ask parents/caregivers for collaterals who can provide insight regarding their relationship with the child

Initial Interview: Talking about the Incident

- **Now I'd like to ask you what happened when you:**
  - noticed the child having problems, OR
  - last saw the child acting normally, OR
  - WHATEVER BEST FITS THE CASE
- **The questions above are critical for developing Timelines and scene investigation**

Interviewing: Other Common Concerns and Tips

- Information gathered is more credible evidence when it is corroborated!
- Pay attention to the source of information. If it is important to know how the child is doing in school, do not rely on the parent's representation -- ask the teacher.
  - Witnesses and family should be asked to corroborate info about paramour and other critical information relevant to investigation.
  - Remind workers that collaterals who would likely have relevant information should be questioned during an investigation.
    - **Ask yourself: *Who are the collaterals? What's the***

Ending an Initial Interview

- Ask for and welcome questions
- Summarize next steps and time frames
  - Set up next meeting
- Leave door open for further questions
- Update contact information
  - What is the best way and the best time to reach you? Be sure to let me know if you change your number or move. Is there a friend/relative that I can call if I have trouble reaching you?

After Initial Interviews

- Strategies apply to all initial interviews throughout the investigation
- Using the initial information
  - What does this tell me?
  - What else is needed?
  - What is still unclear?
- Next steps
  - Plan to follow up.
  - Who else should I talk with about that?
- Document quickly and clearly
  - You will remember much more of what you did, what evidence was gathered, and about sequences of events if you document quickly
- Suggestions?

Use of Timelines in Multiple-Caregivers Head Trauma Investigations

PRACTICE STRATEGIES & APPROACHES

Timelines

- The importance of <u>timing:</u>
  - **History** provides potentially vital information about
    - previous incidents
    - Presence/absence of risk issues (e.g., harmful parenting, negative views of child, DV)
    - Patterns of relevant behavior (e.g., approach to parenting, how & when child was brought to day care, when parent starts job)
  - Timelines of events *surrounding* the incident
    - Recent and historical incidents and injuries

- Timeline: *a linear representation of important events in the order in which they occurred*.

Timelines: Purposes and Functions

- The more detailed the timeline, the more likely the cause of the injury will be accurate
- Helps assess/establish credibility of caregivers and others collaterals and the explanation of the injury
- Compare consistency of who/what/where/when statements
  - For individual respondents (at different times)
  - Between different respondents
- Having a clear initial timeline for the maltreatment before interviewing someone (Cage & Salus) may provide you with helpful context for assessing and following up on their responses

Doing Timelines

- Who, what, and where…
  - Timelines are all about the **When**?
    - Telling the story of “what happened”
    - Review last 72 hours (per scene investigation)
    - Gather timelines from multiple perspectives (e.g., different caretakers, child and perpetrator, others involved with caretakers or child)
- Doing timelines for caretakers for each injury (difficult but important)

Analyzing Timeline Data

- Try to present it on paper so you can see the sequence of events and the time
- Making comparisons:
  - (In)consistency of details over time by same person (given at different times or in response to different questions)
  - Differences between respondents statements
- Inquire about discrepant or potentially relevant details (in M):
  - Why did he still have his pajamas on that morning?
  - Changes or additions to story
  - Other?

Conducting Scene Investigations

PRACTICE STRATEGIES & APPROACHES

Scene Investigation

- Is a systematic investigative strategy that can help you assess the credibility of the explanation of the injury;
- Must include a scene re-enactment of the incident that was alleged to have caused the injury(s) to the child;
- Is more than the SACWIS Checklist requirement for “Observed Environment where Maltreatment Occurred.”
- Compare the verbal statements about what happened with the observation of the environment and the scene re-enactment.

Scene Re-enactment

AFTER you have interviewed respondents about what happened:

- Ask the people involved to demonstrate what happened, one at a time;
- Bring a doll to the scene but do not bring the doll out until you are ready to do the reenactment;
- Starting at the time the person last saw the child before the injury (or before the injury was discovered) you want them to place and move the doll to explain what happened as they demonstrate;
- If the injury happened outside the home, you must talk to the people who live with and take care of the infant/child.

Supervision and Documentation

SUPPORTIVE ROLE OF THE RA, AA, AND SUPERVISOR:

ASKING QUESTIONS
TIMELINESS AND QUALITY OF INVESTIGATIVE DOCUMENTATION

Asking the Right Questions

- **Supervisors at all levels play a key role by:**
  - Ensuring the thoroughness of the investigation
  - Escalating issues to upper management for support
  - Asking the questions to promote critical thinking
  - Probing areas of investigative anchoring and bias

Supervisory Review of Investigative Practice and Documentation: Quality vs. Completion

- **Supervisors Must Ensure Comprehensive:**
  - Interviews
  - Gathering of Supporting Documents
    - Medical reports
    - Police reports
    - Prior history
  - Follow up –
    - Seeking corroborating evidence
    - Reconciling conflicting information
  - SACWIS Documentation – beyond completing radio buttons on the checklist!

Best Practices in Investigations